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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **TRISH LYNN BULLMAN** **4753 Crestone Peak Court** **Antioch, California 94531** **Registered Nurse No. 640861** Respondent.	Case No. 2011-412 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 21, 2004, the Board of Registered Nursing issued Registered Nursing License Number 640861 to Trish Lynn Bullman (Respondent). The Registered Nursing License was in full force and effect at all times relevant to the charges alleged in this Accusation and will expire on November 30, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in relevant part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in relevant part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Section 2811(b) of the Code provides, in relevant part, that the Board may renew an expired license at any time within eight years after the expiration.

6. Section 118(b) of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states, in relevant part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it."

8. Section 2762 of the Code states, in relevant part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

"(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single

situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

10. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

11. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the

client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

12. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

"(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

DRUG STATUTES

13. Dilaudid is a brand name for Hydromorphone. Hydromorphone is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(k), and a dangerous drug as designated by Business and Professions Code section 4022.

14. Valium is a brand name for diazepam. Diazepam is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(9), and a dangerous drug as designated by Business and Professions Code section 4022.

15. Morphine is a Schedule II controlled substance as designated by Health and Safety Code section 11055(a)(1)(M), and a dangerous drug as designated by Business and Professions Code section 4022.

16. Hydrocodone is a Schedule III controlled substance as designated by Health and Safety Code section 11055(b)(1)(J)), and a dangerous drug as designated by Business and Professions Code section 4022.

COST RECOVERY

17. Section 125.3 of the Code provides, in relevant part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of

the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE
(Unprofessional Conduct)
((Bus. & Prof. Code §§ 2761(a)(1) and 2762(e))

18. Respondent has subjected her nursing license to discipline for unprofessional conduct under Code section 2761(a) as defined by Code section 2761(a)(1)(incompetence, or gross negligence in carrying out usual certified or licensed nursing functions) and Code section 2762(e) in that she diverted narcotic medication and provided false documentation in a medical record while working as a nurse at Sutter Delta Medical Center (Sutter) in Antioch, California, The circumstances are as follows:

19. On July 19, 2007, Patient A's chart indicated a physician's order for Dilaudid 3 mg and Phenergan 25 mg. These pain medications were given at 1:30 p.m. and 1:32 p.m. by an Emergency Department (ED) nurse. Patient A's chart had a note written by Dr. Chavez that stated that Patient A is "pain free" as of 1500 hours (3:00 p.m.). A discharge note indicated that Patient A was discharged at 1515 hours (3:15 p.m.). However, Respondent wrote in Patient A's chart that Dr. Chavez gave a verbal order for Dilaudid 1 mg for Patient A at 1535 hours (3:35 p.m.). Respondent wrote an additional discharge note at 1530 hours (3:30 p.m.) stating that Patient A had requested additional pain medication. Respondent also notes in Patient A's chart that an additional dose of Dilaudid 1 mg was administered to Patient A at 1540 (3:40 p.m.).

20. On July 23, 2007, during an interview with Dr. Chavez regarding his care of Patient A on July 19, 2007, Dr. Chavez denied having given a verbal order for anyone to give additional pain medication for Patient A since her pain was relieved as of 1500 hours (3:00 p.m.). Patient A was interviewed by telephone on July 22, 2007. She indicated that on July 19, 2007 she received a shot of Dilaudid 3 mg in one arm and a shot of Phenergan 25 mg in the other arm. She denied, however, receiving additional pain medication because she was pain free.

21. Subsequently, Respondent admitted that she did not receive a verbal order from Dr. Chavez for the Dilaudid for this patient on July 19, 2007 and also admitted to falsely

documenting the verbal order in the patient's medical record. Respondent was terminated from Sutter for falsification of documents.

SECOND CAUSE FOR DISCIPLINE
(Unprofessional Conduct)
((Bus. & Prof. Code §§ 2761(a) and 2761(a)(1))

22. Respondent has subjected her nursing license to discipline for unprofessional conduct under code section 2761(a) as defined by Code section 2761(a)(1)(incompetence, or gross negligence in carrying out usual certified or licensed nursing functions) in that Respondent withdrew narcotics without physician authorization and failed to properly document the use of medication while working as a Nurse at Sutter Tracy Community Hospital (STCH). The circumstances are as follows:

23. On or about April 18, 2008, Respondent was suspended from STCH pending an investigation into narcotic discrepancies (associated with Respondent) discovered by the pharmacy. Respondent resigned shortly after she was suspended. An investigation by the STCH revealed that on 10 separate occasions Respondent removed Dilaudid from the Pyxis machine[1] without a physician's order and that on seven of those occasions, Respondent did not properly handle narcotic waste. During the investigation, STCH reviewed the medical charts of nine patients who Respondent treated from April 10, 2008, through April 14, 2008. The narcotic discrepancies that appeared in several of these patients' medical charts are explained below:

Patient 2

24. On April 10, 2008, at 2:12 p.m. Respondent removed Dilaudid 1 mg from the Pyxis machine without a physician's order. There was no documentation that the medication was administered or wasted.

Patient 3

25. On April 10, 2008, at 3:25 p.m. Respondent removed Dilaudid 1 mg from the Pyxis machine without a physician's order and there is no documentation that the medication was administered or wasted.

[1] A Pyxis machine is an automated dispensing system for medications kept in nursing units.

26. On April 10, 2008, at 7:04 p.m. Respondent returned Dilaudid 1 mg to the Pyxis machine without a physician's order.

Patient 4

27. On April 11, 2008, at 9:59 a.m., Respondent removed Dilaudid 1 mg from the Pyxis machine. There was no documentation of the medication being administered. However, Respondent did document wasting .5 mg of Dilaudid at 1:22 p.m. that same day.

Patient 5

28. On April 11, 2008, at 1:44 p.m., Respondent removed Dilaudid 1 mg from the Pyxis machine without a physician's order. There was no documentation of the medication being administered or wasted.

Patient 6

29. On April 14, 2008, at 9:19 a.m., Respondent removed Dilaudid 1 mg from the Pyxis machine without a physician's order. There was no documentation of the medication being administered or wasted. However, at 11:55 a.m. Respondent returned Dilaudid 1 mg to the Pyxis machine.

Patient 8

30. On April 14, 2008, at 10:19 a.m., Respondent removed Dilaudid 1 mg from the Pyxis machine without a physician's order. There was no documentation of the medication being administered or wasted.

Patient 9

31. On April 14, 2008, at 11:40 a.m., Respondent removed Dilaudid 1 mg from the Pyxis machine without a physician's order. There was no documentation of the medication being administered or wasted.

32. On April 14, 2008, at 2:30 p.m., Respondent removed Dilaudid 1 mg from the Pyxis machine without a physician's order. There was no documentation of the medication being administered or wasted.

33. On April 14, 2008 at 3:12 p.m., Respondent returned Dilaudid .5 mg to the Pyxis machine.

34. Respondent's handling of medication and the procedures she used to maintain documentation of her use of medication is not consistent with the standard policies and procedures at STCH.

THIRD CAUSE FOR DISCIPLINE
(Unprofessional Conduct)
((Bus. & Prof. Code §§ 2761(a) and 2761(a)(1))

35. Respondent has subjected her nursing license to discipline for unprofessional conduct under Code section 2761(a) as defined by Code section 2761(a)(1)(incompetence, or gross negligence in carrying out usual certified or licensed nursing functions) in that Respondent resigned from her position at Kaiser Permanente-Antioch Medical Center (KP-AMC) on or about September 18, 2009, in lieu of being terminated for narcotic diversion and for not following the medical center's policies and procedures for medication administration and documentation. The circumstances are as follows:

36. Due to suspicions from the KP-AMC pharmacy regarding narcotic diversions by Respondent, KP-AMC conducted an audit regarding the use of the Pyxis machine. This audit revealed several narcotic removal and waste discrepancies. Further KP-AMC staff reviewed five patient medical records which demonstrated several narcotics removal and waste discrepancies between June 14, 2009 and July 21, 2009, attributable to Respondent. The discrepancies in the medical records of the five patients is explained below and are listed as Patient A, B, C, D, and E, respectively.

Patient A.

On June 14, 2009, at 3:09 p.m., Respondent removed Dilaudid (hydromorphone) 1 mg from the Pyxis machine by "override" without a physician's order. There was no documentation that the medication was administered and there was no documentation of waste. The patient for which the hydromorphone was dispensed was discharged at 3:22 p.m. on June 14, 2009.

Patient B.

On June 14, 2009, at 3:37 p.m., Respondent removed 10 mg of Valium (diazepam) from the Pyxis machine. Respondent documented that she administered 5 mg of Valium at 3:31 p.m. The remaining 5 mg of Valium is unaccounted for as there is no documentation of waste.

Patient C.

On June 28, 2009, at 4:44 p.m., Respondent removed 4 mg of morphine from the Pyxis machine. This was done without a physician's order and there was no documentation that the morphine was administered or wasted. Subsequently, at 8:08 p.m., Respondent removed 4 mg of morphine from the Pyxis machine. Respondent documents that she administered the drug at 8:00 p.m., before the medication was withdrawn from the Pyxis machine. At 8:29 p.m., Respondent removed 4 mg of Morphine from Pyxis without a physician's order. Further there was no documentation that the medication was administered or wasted.

Patient D.

From 2:10 p.m. to 4:52 p.m., on July 20, 2009, Respondent removed 5 mg of Dilaudid from the Pyxis machine. On three occasions during this time she removed 1 mg of Dilaudid and on one occasion she removed 2 mg of Dilaudid. Each of these removals was done without a physician's order and there was no documentation that the medication was administered or wasted. At 8:17 p.m., Respondent conducted a cabinet override and removed Dilaudid 1 mg from the Pyxis machine without a physician's authorization. Respondent administered .5 mg of the Dilaudid but the remaining .5 mg was not documented as administered or wasted. Subsequently, at 10:38 p.m., Respondent removed two doses of Dilaudid 1 mg from the Pyxis machine. The Medication Administration Record (MAR) indicates that another nurse (Mary Falk) administered one of the doses of Dilaudid 1 mg at 8:40 p.m. The other dose of Dilaudid 1 mg is not accounted for in any documentation. At 11:23 p.m., Respondent removed two doses of Dilaudid 1 mg from the Pyxis machine without a physician's order. There is no documentation that this medication was administered or wasted.

Patient E.

On July 21, 2009, at 11:19 a.m., Respondent removed Dilaudid 1 mg from the Pyxis Machine. Respondent documented that she did not administer the medication because Patient E's symptoms were resolved. However, there is no record that the medication was wasted. From 11:50 a.m. until 7:15 p.m., Respondent removed Dilaudid 1 mg from the Pyxis machine on six

separate occasions. On all these occasions there is no documentation that the medication was administered or wasted.

37. Respondent acted incompetently and with gross negligence when she withdrew controlled substances (Dilaudid, Morphine, and Valium) and failed to properly note its disposition on the MAR or any other hospital record. Respondent diverted at least seventeen narcotic medications consisting of at least 16.5 mg of Dilaudid, 8 mg of morphine, and 5 mg of Valium. Respondent further acted incompetently and with gross negligence when she withdrew controlled substances without a specific order from a physician.

FOURTH CAUSE FOR DISCIPLINE
(Unprofessional Conduct)
((Bus. & Prof. Code § 2762(b))

38. Respondent has subjected her nursing license to discipline for unprofessional conduct under code section 2762(b)(unprofessional conduct relating to controlled substances or dangerous drugs) in that on or about February 1, 2010, after narcotic dispensing discrepancies were discovered, Maximum Health Care Services, Respondent's employer, asked Respondent to provided a urine specimen for screening which tested positive for Morphine.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nursing License Number 640861, issued to Trish Lynn Bullman;

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2. Ordering Trish Lynn Bullman to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 11-1-10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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